# IPRS

## Integrated Payment
## and Reporting System

# 837 Reporting Requirements

Version 1.**14**

**August 2005**

# The 837 Transaction Set

The ANSI X12N 837 transaction set is used to report claims to MMIS+. The same transaction set is used to report both Medicaid and DMH/DD/SA claims. MMIS+ routes the each claim to the appropriate financial payer, based on eligibility and service information reported on the claim. This file is transmitted electronically to IPRS by the Local System Administrator.

All Medicaid and DMH/DD/SA claims must be reported using the 837 transaction set EXCEPT:

- Medicaid claims with third party liability attachments

When reporting to MMIS+ using the 837:

- Client ID can be Medicaid ID, or any ID cross-referenced to that ID in CNDS/IPRS.

- ICD 9 primary diagnosis required. Additional diagnoses can be reported if applicable.

- Decimal quantity units of service are accepted by IPRS. An hourly service can be submitted as 1.5 for 1 hour, 30 minutes.

*Three providers must be reported on the claim:*
- **Billing provider** - files claims and receives payments, used to route claim to best financial payer.
- **Attending provider** - agency / program that renders service, used to determine the best population group.
- **Referring provider** - Responsible LMA, whose budget will pay for the service

# Claims Filing - Overview of User Tasks

The Integrated Payment and Reporting System (IPRS) is a claims processing system that will pay Division of MH/DD/SA (DMH) funds for claims submitted by billing providers enrolled in IPRS. The IPRS replaces volume of service reporting for Pioneer, At-Risk Children and MRMI UCR systems. The Medicaid Management Information System (MMIS) is a claims processing system that pays Division of Medical Assistance (DMA) funds for claims submitted by billing providers enrolled in MMIS. IPRS together with the MMIS comprise the MMIS+.

Area programs are enrolled as billing providers in both IPRS and MMIS. Claims are sent by area programs to the MMIS+ in the same format for both IPRS and MMIS. The MMIS+ system determines the 'best payer' based on information on the claim.

EDS is the fiscal agent that operates the MMIS+. Claims are submitted to EDS for processing.

Below is the process used to submit claims to MMIS+:

*Enter billable activity into local client accounting system.*

Each billing provider enters records of services provided in their local client accounting system. The local client accounting system stores the service activity records, and submits billable activities to 'Payers'. Medicaid and DMH are designated as payers in the local client accounting systems.

*New claims are submitted to MMIS+ in an electronic format.*

The local client accounting system stores and submits a group (batch) of claims.  For MMIS+, claims are submitted in an Electronic Format that is compliant with a national standard called ANSI X12N 837.  This is the standard required by HIPAA.  The client accounting system generates a file in the 837 format, and the computer administrator transmits that file to an EDS electronic mailbox.  Claims can be submitted daily.

### *Review the Electronic Acknowledgement for files submitted electronically.*

After an 837 file is transmitted to the EDS mailbox, two files will be generated to acknowledge the receipt of the transactions and report certain types of problems in the transaction set.  These files should be reviewed by the sender and are called 997 functional acknowledgement and U277 unsolicited response.

### *Adjustment claims, and Medicaid claims with Third Party Liability, are mailed to EDS.*

Certain types of claim activity must be done using hard copy claims and attachments.  This includes adjustment claims, and Medicaid claims when the recipient has other third party coverage. This will need to be changed. See Linda

### *On Fridays, the MMIS+ performs claims payment processing (a "Checkwrite cycle").*

Generally, checkwrite cycles are run the 1$^{st}$, 2$^{nd}$ and 3$^{rd}$ Fridays of each month.  A schedule is published annually and distributed to billing providers.  Claims that were submitted since the previous checkwrite cycle are routed to the best payer, assigned an Internal Claim Number (ICN) and processed.  Some claims that were partially processed during previous cycles may also be re-processed, such as suspended claims, deny-re-enter claims, and system generated claims for retroactive Medicaid eligibility or retroactive rate revisions.

# Filing a Claim

Using the ASC X12N 837 – Health Care Claim for Professional Claims transaction set, claims are submitted electronically for both Medicaid and IPRS to the North Carolina MMIS+.  Electronic claims submission offers the provider a low cost, highly reliable alternative to paper claim submission.  No paper claims will be accepted, except Medicaid claims with Third-Party Liability and adjustments.

| | |
|---|---|
| **Note** ☞ | *Only claims received from IPRS enrolled billing providers will be processed in IPRS.* |

# Steps to Begin Electronic Billing

**1.** Establish a TPA with Electronic Data Systems

The TPA is a legal document that identifies the EDI partners, transaction sets, usage of data requirements, and file specifications.  The TPA has already been completed for billing providers during the pilot site implementation.  Permanent procedures will be implemented once fiscal agent services are established.

**2.** Notify Software Vendor
- Billing electronically requires software capable of connecting to the EDS Bulletin Board (electronic mailbox).
- Instruct your software vendor to write a program using specifications outlined in the TPA for data requirements of the ASC X12N 837 – Health Care Claim for Professional Claims transaction set

**3.** Signature Requirements

Since it is not possible for the provider to sign claims submitted electronically, the provider must sign and return an Electronic Claims Submission Agreement prior to the submission of claims.  The agreement will be retained by the DMA and DMH to serve in lieu of the provider's signature for each claim submitted electronically.  To obtain this form, contact EDS.

Upon receipt of the ECS agreement, sign and return all copies to:

| | |
|---|---|
| Division of Medical Assistance | DMH/DD/SA |
| 1985 Umstead Drive | Data Operations |
| Raleigh, NC  27603 | 3019 Mail Service Center |
| Attn:  Recipient & Provider Services | Raleigh, NC  27699-3019 |

DMA and DMH will retain one copy of the agreement and return one copy to the provider.

**4.** Authorization Numbers

Upon receipt of an approved TPA and ECS agreement, the provider will contact EDS to have a logon authorization number and password assigned.  Once assigned, the Logon Authorization Number will be made active for testing only.  The logon authorization number is initially set up as TEST in order to verify data accuracy and to ensure successful data transmissions.  No electronic claims will be paid until testing is complete.

**5.** Testing Requirements for new IPRS Providers

Before electronic claims can be processed for payment, testing of claims submission procedures must be successfully completed.  Test claims will be checked thoroughly to verify compliance with file specifications.

Submit between 5 to 20 claims for a TEST.  These claims can be previously paid claims, or new claims to be submitted for payment at a later date.  Claims must have valid information (i.e., valid recipient identification numbers, provider number(s), diagnosis, procedure codes, etc) and dates of service must not be over one year old.  Claims will be tested to make sure the billing information and formats are correct.

After your claims are received, the EDS Testing Coordinator will process the transmission and determine the appropriate action to take.  Testing may require one or more submissions depending on the severity of formatting and data errors.  The EDS Testing Coordinator will contact providers with test results within 5 to 7 business days.  After successful completion of testing, the logon authorization number and password will be activated for production. From this point forward all claims processed will be paid according to the policies of DMH/DD/SA Services.  No payment will be made on test claims.  After testing is complete, the provider is responsible for resubmitting the claims used during testing in order for the claims to be processed for payment.

# Special Considerations

Changes to software or hardware after claim submission has begun may result in unexpected results.  If a change occurs in your system, contact EDS and request a testing logon authorization number.

### Helpful Hints for Testing
During testing, providers often fail on their first attempt for various reasons.  Listed below are helpful hints for successful testing:
- Learn and understand how to bill IPRS ANSI X12N 837, (see both the HIPAA Implementation Guide and the IPRS Layout section of this requirements document).
- Do not include dashes or place spaces within the recipient's Medicaid or IPRS identification number.
- Do not include decimal points or place spaces with the diagnosis code(s).

### Hours of Operation for Filing Claims
EDS receives claims submitted electronically via an Electronic File Transfer Process.  Claims may be submitted 7 days a week 24 hours a day.  Only claims received by the EDI translator by 5:00 PM on Fridays will be processed by that week's checkwrite cycle.

### Multi-detail vs. Single-detail

IPRS accepts health insurance claims for professional services.  Before MMIS+ and IPRS, these claims were filed using the HCFA 1500 format.  Claims are now filed using the ANSI X12N 837 professional claim format.  A claim filed by a billing provider for a recipient can contain more than one service level detail line.  For example, Duplin Sampson (billing provider) can submit a claim for John Doe (recipient) who received one service event on March 1st and another service event on March 8th.  If both service events are filed on the same claim, this is a multi-detail claim.  On the 837, for the same "subscriber" (recipient), more than one LX and SV segment is contained with the same 2000B loop.

It is strongly recommended that claims be filed as single-detail claims.  For the example above, the Loop 2300 – Claim Information (CLM) segment should be repeated for each separate LX, SV segment.  For single-detail claims, LX should always be followed by a '1'.

### Multi-detail Claims Problems

If multi-detail claims are submitted, the following problems occur during claims processing:

- One detail of a multi-detail claim cannot suspend when another detail pays or denies.  All details of a multi-detail claim will be adjudicated to pay or deny.
- Financial processing of adjustments for multi-detail claims is more complex, resulting in unprocessed adjustments for some claims.
- Retroactive Medicaid adjustments will have to be filed manually for multi-detail claims.
- All details of claim will process using the Header level Referring and Rendering Provider information, even if submitted specific to the detail.

### 837 Transaction Set Header/Trailer and 997 Transaction Set/Functional Group Response Trailer

The 837 Transaction Set Header (ST Segment) indicates the start of a transaction.  The 837 Transaction Set Trailer  (SE Segment) indicates the end of the transaction set and provides a count of the transmitted segments (including the beginning (ST) and ending (SE) segment).   The 997 Transaction Set Response Trailer (AK5 Segment) is used to acknowledge acceptance or rejection and report errors in a transaction set.  The 997 Functional Group Response Trailer (AK9 Segment) is used to acknowledge acceptance or rejection of a functional group and report the number of included transaction sets from the original trailer, the accepted set, and the received sets in the functional group.  This simply means that for every ST/SE segment in the 837 transaction set, there is a corresponding AK5 segment in the 997 and for every transmission there is an AK9 segment in the 997 transaction set.   In order to validate the status of each claim using the 997, every claim submitted by the billing provider must begin with an ST segment and end with an SE segment.  This results in multiple ST/SE segments in one transaction. The billing provider can use the 997 to easily identify that the claim was accepted by the system for processing.  See the following example.

| Example: | 3 claims are transmitted via 837 transaction set.  There are ST/SE segment for claims 1 and 2.  Claim 3 has an ST segment, but is missing an SE segment.  Using the 997, the billing provider receives an AK5 for each ST segment.  The AK9 line as highlighted below informs the billing provider that the transaction is partially accepted (P).  The first 3 indicates there were 3 claims in the transaction.  The next 3 indicates there were 3 total claims. The 2 indicates that only 2 claims were accepted.  The 4 in the AK9 defines the type of error in the 837 transaction.  In this particular example, the error is the result of a missing SE segment for claim 3 in the 837 transaction. (Please refer to the 997 Functional Acknowledgment section of the 837 Implementation Guide for additional information about the 997.) |
|---|---|

<div>

**837**
```
ST*837*12345~
.......~
Claim 1 Header.....~
Claim 1 Detail.......~
.......~
SE*1*12345~
ST*837*23456~
......~
Claim 2 Header....~
Claim 2 Detail......~
......~
SE*1*23456~
ST*837*34567~
......~
Claim 3 Header....~
Claim 3 Detail......~
......~
```

**997**
```
ST*997*98765~
AK2*837*12345~
AK5*A~
AK2*837*23456~
AK5*A~
AK2*837*34567~
AK5*A~
AK9*P*3*3*2*4~
SE*9*98765~
```
</div>

# Claims Filing Required Fields-Procedure Codes

## Procedure Codes

Whenever possible, standard procedure codes are used in MMIS and IPRS. When a procedure code is valid in both IPRS and MMIS, claim will be routed to the best payer based on client eligibility and provider enrollment. However, IPRS also includes procedure codes that are not valid in MMIS. These procedure codes are for services that are covered by DMH benefit plans, but not by Medicaid. Examples are Consultation, Education and Primary Prevention (YP110), Case Support (YP220), and Residential Supports (YM850).

Procedure codes have been assigned using the following guidelines:

- Whenever possible, national standard HCPCS codes have been used. These codes are five digit numbers that begin with '9'. The unit of service for many of the HCPCS codes is one unit for one event. However, some HPCPS codes use 15 minute or daily units. In general, these codes are valid for both IPRS and MMIS.
- Codes previously used in the Pioneer UCR are the Pioneer service code, preceded with a 'YP'. The units of service for these codes are 15 minute units for periodic and day treatment/activity, and day units for residential. These codes are not valid for MMIS.
- Codes previously used in the MRMI (Thomas S.) UCR are the MRMI service code, preceded with a 'YM'. The units of service for these codes are 15 minute units for periodic and day treatment/activity, and day units for residential. These codes are not valid for MMIS.
- Codes previously used in the CTSP (ARC) UCR are the CTSP service code, preceded with a 'YA'. The units of service for these codes are 15 minute units for periodic and day treatment/activity, and day units for residential. These codes are not valid for MMIS.

It is important to understand that each population group has a benefit plan that covers a defined set of procedures. If a procedure is not covered by the benefit plan for a population group, the claim will be routed to a different population group that covers the service (if the client and provider are eligible in more than one population group.) If there is not a match between a client's eligibility, a provider's eligibility and a procedure covered by a benefit plan, the claim will deny.

# The 837 Transaction Set

## Definition of Required Fields for the 837 Transaction Set

*Required Fields:*
**837 Transaction Summary**

| Loop/Segment | Comment |
|---|---|
| TRANSMISSION HEADER ||
| ISA Interchange Control Header | Repeat 1 time per transaction set |
| GS Functional Group Header | |
| ST TRANSACTION SET HEADER | Repeat for each different transaction set in the transmission. |
| BHT  Beginning of Hierarchical Transaction | |
|     Transmission Type Identification | |
| Loop 1000A - Submitter Name | |
|     Submitter EDI Contact Information | |
| Loop 1000B - Receiver Name | |
| BILLING PROVIDER ||
| Loop 2000A Billing/Pay-To Provider Hierarchical Level | Repeat for each different billing provider in the 837 transaction set (ST), incrementing HL count for each additional billing provider. |
|     Billing/Pay-To Provider Specialty Information | |
| Loop 2010AA - Billing Provider Name | |
|     Billing Provider Address | |
|     Billing Provider City/State/Zip Code | |
|     Billing Provider Secondary Identification | |
| SUBSCRIBER ||
| Loop 2000B - Subscriber Hierarchical Level | Repeat for each different client within the billing provider in LOOP 2000A, incrementing HL count for each additional client within the billing provider. |
|     Subscriber Information | |
| Loop 2010BA - Subscriber Name | |

| Loop/Segment | Comment |
|---|---|
| Subscriber Street | |
| Subscriber City/State/Zip Code | |
| Demographic Information | |
| Loop 2010BB - Payer Name | |
| CLAIM | |
| Loop 2300 - Claim Information | Repeat for each claim for client in LOOP 2000B |
| Date Initial Treatment (Situational) | SITUATIONAL – Not required for IPRS, Required for Medicaid when reporting Specialized Therapies. |
| Date Accident (Situational) | |
| Claim Supplemental Information (Situational) | SITUATIONAL – Not required for IPRS, Required for Medicaid F2 Stamp usage |
| Claim Reference (Situational) | SITUATIONAL – Required when submitting Replacement or Void Transactions |
| Medicaid Record Information | |
| Health Care Diagnosis Code | |
| Loop 2310A – Referring Provider Name | |
| Referring Provider Specialty Information | |
| Referring Provider Secondary Information | |
| Loop 2310B - Rendering Provider Name | SITUATIONAL LOOP – Required when Rendering Provider is different from Billing Provider. |
| Rendering Provider Specialty Information | |
| Rendering Provider Secondary Information | |
| Loop 2310D – Service Facility Location | |
| Service Facility Location Street | |
| Service Facility Location City/State/Zip Code | |
| Service Facility Location Secondary Identification | |
| Loop 2320 - Other Subscriber Information (Situational) | SITUATIONAL LOOP - Not required for IPRS, Required by Medicaid when reporting TPL. |
| Payer Paid Amount | |
| Subscriber Demographic Information | |
| Other Insurance Coverage Information | |
| Loop 2330A - Other Subscriber Name | SITUATIONAL LOOP - Not required for IPRS, Required by Medicaid when reporting TPL. |
| Loop 2330B - Other Payer Name | SITUATIONAL LOOP - Not required for IPRS, Required by Medicaid when reporting TPL. |
| Date Paid | |
| Paid Claim Number | |

| Loop/Segment | Comment |
|---|---|
| SERVICE DETAIL || 
| Loop 2400 – Service Line | Repeat for each service detail line for the claim LOOP 2300. |
|     Professional Service | |
|     Service Date | |
|     Line Item Control Number | |
| Loop 2420A - Rendering Provider Number | SITUATIONAL LOOP – Required when Rendering Provider is different from Header Level Rendering Provider.  NOTE:  Data is information only at this level.  Claims processing will occur using the header level information only. |
|     Rendering Provider Specialty Information | |
|     Rendering Provider Secondary Identification | |
| Loop 2420F - Referring Provider Number | SITUATIONAL LOOP – Required when Referring Provider is different from Header Level Referring Provider.  NOTE:  Data is information only at this level.  Claims processing will occur using the header level information only. |
|     Referring Provider Specialty Information | |
|     Referring Provider Secondary Identification | |
| Loop 2430 - Service Line Adjudication (Situational) | SITUATIONAL LOOP- Not Required by IPRS, Required by Medicaid when reporting TPL for the detail line |
|     Line Adjustment Information (Situational) | SITUATIONAL- Not Required by IPRS, Required by Medicaid when reporting TPL where the paid amount was different from the original billed amount |
|     Date Paid (Situational) | SITUATIONAL- Not Required by IPRS, Required by Medicaid when reporting TPL |
| TRANSACTION TRAILER || 
| Transaction Set Trailer | Must match ST |
| Functional Group Trailer | Must match GT and ISA |
| Interchange Control Trailer | |

## 837 Transaction Layout

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|---|
| **INTERCHANGE CONTROL HEADER** | | | **Occurs 1 time** | | **Required** |
| ISA | Interchange Control Header | | 8 | ISA | HIPAA Requirement |
| ISA01 | Authorization Information Qualifier. | | 2/2 | 00 - No Authorization Info Present | HIPAA Requirement |
| ISA02 | Authorization Information | | 10/10 | | Optional |
| ISA03 | Security Information. Qualifier | | 2/2 | 00 - No Security Info Present | HIPAA Requirement |
| ISA04 | Security Information | | 10/10 | | Optional |
| ISA05 | Interchange ID Qualifier | | 2/2 | ZZ - Mutually Defined Id for Sender in ISA06 | HIPAA Requirement |
| ISA06 | Interchange Sender ID. | | 15/15 | Sender ID = Number from Trading Partner Agreement | HIPAA Requirement |
| ISA07 | Interchange ID Qualifier | | 2/2 | ZZ - Mutually Defined Id for Sender in ISA08 | HIPAA Requirement |
| ISA08 | Interchange Receiver ID | | 15/15 | DNC00 | HIPAA Requirement |
| ISA09 | Interchange Date | | 6/6 | Date of the Interchange in YYMMDD format | HIPAA Requirement |
| ISA10 | Interchange Time | | 4/4 | Time of the Interchange in HHMM format | HIPAA Requirement |
| ISA11 | Interchange Control Standard Identification | | 1/1 | U - US EDI Community of ANSI X12 standards | HIPAA Requirement |
| ISA12 | Interchange Control Version Number | | 5/5 | 00401 - Version of above Standards | HIPAA Requirement |
| ISA13 | Interchange Control Number | | 9/9 | 000000001 – Number assigned by sender. Must = the number in IEA02 | HIPAA Requirement |
| ISA14 | Acknowledgment Requested | | 1/1 | 1 - Code requesting an acknowledgement record | HIPAA Requirement |
| ISA15 | Usage Indicator | | 1/1 | T - Test Data P- Production Data | HIPAA Requirement |
| ISA16 | Component Element Separator | | 1/1 | Delimiter used to separate component elements | HIPAA Requirement |
| Example Segment   ISA*00*       *00*       *ZZ*123456789     *ZZ*DNC00         *000901*1705*U*00401*000000001*1*T*:~ | | | | | |
| **FUNCTIONAL GROUP HEADER** | | | **Occurs 1 time** | | **Required** |
| GS | | Functional Group Header | 2/2 | GS | HIPAA Requirement |
| GS01 | | Functional Id Code | 2/2 | HC – Health Care Claim | HIPAA Requirement |
| GS02 | | Application Senders Code | 15/15 | Same number as ISA06 - Identifies the Sender | HIPAA Requirement |
| GS03 | | Application Receivers Code | 15/15 | Same number as ISA08 - Identifies the Receiver | HIPAA Requirement |
| GS04 | | Date | 8/8 | CCYYMMDD - Group date | HIPAA Requirement |
| GS05 | | Time | 4/8 | HHMM - Group time | HIPAA Requirement |
| GS06 | | Group Control Number | 1/9 | Control number from sender | HIPAA Requirement |
| GS07 | | Responsible Agency Code | ½ | X – Accredited Standards Committee | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|---|
| GS08 | | Version/Release ID Code | 1/12 | 004010X098A1 - Version of above Standards | HIPAA Requirement |
| Example Segment   GS*BE*123456789*DNC00*20000901*1706*0001*X*004010X098A1~ | | | | | |
| **TRANSACTION SET HEADER** | | | **Occurs 1 time** | | **Required** |
| ST01 - p62 | Transaction Set ID Code | | 3/3 | 837 | HIPAA Requirement |
| ST02 - p62 | Transaction Control no. | | 4/9 | Unique no. assigned to transaction set. ST02 and SE02 must be identical. | HIPAA Requirement |
| Example:  ST*837*918273645~ | | | | | |
| **BEGINNING OF HIERARCHICAL TRANSACTION** | | | **Occurs 1 time** | | **Required** |
| BHT01 - p63 | Hierarchical Structure Code | | 4/4 | 0019 - Information Source, Subscriber, Dependent | HIPAA Requirement |
| BHT02 - p64 | Transaction Set Purpose Code | | 2/2 | 00 – Original | HIPAA Requirement |
| BHT03 - p64 | Reference Identification | | 1/30 | The number assigned by the originator to identify the transaction within the originator's business application system. | HIPAA Requirement |
| BHT04 - p64 | Date | | 8/8 | Enter date in CCYYMMDD format. | HIPAA Requirement |
| BHT05 - p65 | Time | | 4/8 | Enter time in HHMM format. | HIPAA Requirement |
| BHT06 - p65 | Transaction Type Code | | 2/2 | CH – Chargeable | HIPAA Requirement |
| Example:  BHT*0019*00*01234*20001006*1000*CH~ | | | | | |
| **Transmission Type Identification** | | | **Occurs 1 time** | | **Required** |
| REF01 -  p66 | Reference Identification Qualifier | | 2/3 | 87 – Functional Category | HIPAA Requirement |
| REF02 - p66 | Reference Identification | | 1/30 | 004010X098A1. | HIPAA Requirement |
| Example: REF*87*004010X098A1~ | | | | | |
| **LOOP 1000A - SUBMITTER NAME** | | | **Occurs 1 time** | | |
| **Submitter Name** | | | **Occurs 1 time per Loop 1000A occurrence** | | **Required** |
| NM101 - p68 | Entity Identifier Code | | 2/3 | 41 – Submitter | HIPAA Requirement |
| NM102 - p68 | Entity Type Qualifier | | 1/1 | 2 – Non-Person Entity | HIPAA Requirement |
| NM103 - p68 | Name Last or Org. Name | | 1/35 | Org Name of Submitter | HIPAA Requirement |
| NM104 - p68 | Not Used | | | Not Used | Optional |
| NM105 | Not Used | | | Not used | Optional |
| NM106 | Not Used | | | Not used | Optional |
| NM107 | Not Used | | | Not used | Optional |
| NM108 - p68 | Identification Code Identifier | | 1/2 | 46 -  Electronic Transmitter Identification Number (ETIN) Established by Trading Partner Agreement | HIPAA Requirement |
| NM109 - p69 | Identification Code | | 2/80 | Submitter Identifier Number – This is the mailbox ID. It is assigned by EDS and included in the TPA.  The mailbox ID is used to validate the submitter in order | Required and Edited |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| | | | to perform EDI transactions. | |
| Example:  NM1*41*2*DUPLIN/SAMPSON*****46*MAILBOX-ID~ | | | | |
| **Submitter EDI Contact Information** | | **Occurs up to 2 times per Loop 1000A occurrence** | | **Required** |
| PER01 - p72 | Contact Function Code | 2/2 | IC – Information Contact | HIPAA Requirement |
| PER02 - p72 | Name | 1/60 | Enter submitter's contact name. | HIPAA Requirement |
| PER03 - p72 | Communication Number Qualifier | 2/2 | TE – Telephone | HIPAA Requirement |
| PER04 - p72 | Communication Number | 1/80 | Phone number of the contact, including area code. | HIPAA Requirement |
| Example:  PER*IC*JAMIE SMITH*TE*9105555555~ | | | | |
| **LOOP 1000B – RECEIVER NAME** | | **Occurs 1 time** | | |
| **Receiver Name** | | **Occurs 1 time per Loop 1000B occurrence** | | **Required** |
| NM101 - p75 | Entity Identifier Code | 2/3 | 40 – Receiver | HIPAA Requirement |
| NM102 - p75 | Entity Type Qualifier | 1/1 | 2 - Non-Person Entity | HIPAA Requirement |
| NM103 - p75 | Name Last or Org. Name | 1/35 | EDS | HIPAA Requirement |
| NM104 | Not Used | | Not used | Optional |
| NM105 | Not Used | | Not used | Optional |
| NM106 | Not Used | | Not used | Optional |
| NM107 | Not Used | | Not used | Optional |
| NM108 - p75 | Identification Code Qualifier | 2/80 | 46 | HIPAA Requirement |
| NM109 - p75 | Identification Code | 2/80 | DNC00 | HIPAA Requirement |
| Example: NM1*40*2*EDS*****46*DNC00~ | | | | |
| **LOOP 2000A BILLING/PAY-TO PROVIDER HIERARCHICAL LEVEL** | | **Occurs as many times as needed** | | |
| **Billing/Pay-to Provider Hierarchical Level** | | **Occurs 1 time per Loop 2000A occurrence** | | **Required** |
| HL01 - p78 | Hierarchical ID Number | 1/12 | Must begin with ""1"" and be incremented by one each time an HL is used in transaction. | Required and Edited |
| HL02 | Not Used | | Not used | Optional |
| HL03 - p78 | Hierarchical Level Code | 1/2 | 20 – Information Source | HIPAA Requirement |
| HL04 - p78 | Hierarchical Child Code | 1/1 | 1 – Additional Subordinate HL Data Segment in this Hierarchical Structure | HIPAA Requirement |
| Example: HL*1**20*1~ | | | | |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| **Billing/Pay-To Provider Specialty Information** | | **Occurs 1 time per Loop 2000A occurrence** | | |
| PRV01 - p79 | Provider Code | 1/3 | BI – Billing | HIPAA Requirement |
| PRV02 - p80 | Reference Identification Qualifier | 2/3 | ZZ – Mutually Defined Health Care Provider Taxonomy Code List | HIPAA Requirement |
| PRV03 - p80 | Reference Identification | 1/30 | 261QM1300X – Ambulatory Health Care Facilities Clinic/Center - Multi-Specialty Provider Taxonomy Code – Used by LMAs.  Other types of billing providers may use a different code  **NOTE – Taxonomy codes are updated on a periodic basis. If submitted, this value will need to be maintained to remain compliant. | HIPAA Requirement |
| Example: PRV*BI*ZZ*261QM1300X~ | | | | |
| **LOOP 2010AA - BILLING PROVIDER NAME** | | **Occurs 1 time per Loop 2000A Occurrence** | | |
| **Billing Provider Name** | | **Occurs 1 time per Loop 2010AA occurrence** | | **Required** |
| NM101 - p85 | Entity Identifier Code | 2/3 | 85 – Indicates billing provider | HIPAA Requirement |
| NM102 - p85 | Entity Type Qualifier | 1/1 | 2 – Non-Person | HIPAA Requirement |
| NM103 - p85 | Name Last or Org Name | 1/35 | Enter billing provider's name. The billing provider's name is mapped into the MMIS+ and IPRS but truncated to 5 bytes | Required and Edited |
| NM104 - p85 | Not Used | | Not Used | Optional |
| NM105 | Not Used | | Not Used | Optional |
| NM106 | Not Used | | Not Used | Optional |
| NM107 | Not Used | | Not Used | Optional |
| NM108 - p86 | Identification Code Qualifier | 1/2 | 24 – Employer's Identification Number | HIPAA Requirement |
| NM109 - p86 | Identification Code | 2/80 | Federal Tax Number | HIPAA Requirement |
| Example: NM1*85*2*DUPLIN/SAMPSON BILLER*****24*12345678~ | | | | |
| **Billing Provider Address** | | **Occurs 1 time per Loop 2010AA occurrence** | | **Required** |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| N301 - p88 | Address Information | 1/55 | Billing provider's address. Note: This is not a means for updating provider information. Use provider enrollment process. | HIPAA Requirement |
| Example: N3*123 HELPFUL STREET~ | | | | |
| **Billing Provider City/State/Zip Code** | | **Occurs 1 time per Loop 2010AA occurrence** | | **Required** |
| N401 - p89 | City Name | 2/30 | Billing provider's city name. | HIPAA Requirement |
| N402 - p90 | State or Province Code | 2/2 | Billing provider's state code. | HIPAA Requirement |
| N403 - p90 | Postal Code | 3/15 | Billing provider's zip code. | HIPAA Requirement |
| Example: N4*DUPLIN/SAMPSON*NC*23110~ | | | | |
| **Billing Provider Secondary Identification** | | **Occurs 1 time per Loop 2010AA occurrence** | | **Required by IPRS** |
| REF01 - p92 | Reference Identification Qualifier | 2/3 | 0B – State License Number<br>1D – Medicaid Provider Number | HIPAA Requirement |
| REF02 - p92 | Reference Identification | 1/30 | Enter billing provider's number. The billing provider's number is mapped into the MMIS+ and IPRS | Required and Edited |
| Example: REF*0B*3404045~ | | | | |
| **LOOP 2000B - SUBSCRIBER HIERARCHICAL LEVEL** | | **Occurs as many times as needed** | | |
| **Subscriber Hierarchical Level** | | **Occurs 1 time per Loop 2000B occurrence** | | **Required** |
| HL01 - p109 | Hierarchical ID Number | 1/12 | Number assigned by the sender to each HL segment within the transmission. | HIPAA Requirement |
| HL02 - p109 | Hierarchical Parent ID Number | 1/12 | Number of next hierarchical data segment that the data segment being described is subordinate to. | HIPAA Requirement |
| HL03 - p109 | Hierarchical Level Code | 1/2 | 22 – Subscriber | HIPAA Requirement |
| HL04 - p109 | Hierarchical Child Code | 1/1 | 0 – No Subordinate HL segment in this hierarchical structure | HIPAA Requirement |
| Example: HL*2*1*22*0~ | | | | |
| **Subscriber Information** | | **Occurs 1 time per Loop 2000B occurrence** | | **Required** |
| SBR01 - p110 | Payer Responsibility Sequence Number Code | 1/1 | P – Primary | HIPAA Requirement |
| SBR02 - p111 | Individual Relationship Code | 2/2 | 18 – Self | HIPAA Requirement |
| SBR03 | Not Used | | Not Used | Optional |
| SBR04 | Not Used | | Not Used | Optional |
| SBR05 | Not Used | | Not Used | Optional |
| SBR06 | Not Used | | Not Used | Optional |
| SBR07 | Not Used | | Not Used | Optional |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| SBR08 | Not Used | | Not Used | Optional |
| SBR09 - p112 | Claim Filing Indicator Code | 1/2 | MC - Medicaid | HIPAA Requirement |
| Example: SBR*P*18********MC~ | | | | |
| **LOOP 2010BA - SUBSCRIBER NAME** | | **Occurs 1 time per Loop 2000B occurrence** | | |
| **Subscriber Name** | | **Occurs 1 time per Loop 2010BA occurrence** | | **Required** |
| NM101 - p118 | Entity Identifier Code | 2/3 | IL – Insured or Subscriber | HIPAA Requirement |
| NM102 - p118 | Entity Type Qualifier | 1/1 | 1 – Person | HIPAA Requirement |
| NM103 - p118 | Name Last or Org Name | 1/35 | Last name of client.  Last name must match CNDS name. The last name (truncated to 5) is mapped into the MMIS+ and IPRS. | Required and Edited |
| NM104 - p118 | Name First | 1/25 | First name of subscriber (patient).  Required if NM102=1. Note:  Only 1st initial of first name is mapped. | Required and Edited |
| NM105 - p118 | Not Used | | Not used | Optional |
| NM106 - p118 | Not Used | | Not used | Optional |
| NM107 - p118 | Not Used | | Not used | Optional |
| NM108 - p119 | Identification Code Qualifier | 1/2 | MI – Member Identification Number | Required and Edited |
| NM109 - p119 | Identification Code | 2/80 | Enter patient's ten-digit Medicaid or IPRS Client ID.  IPRS Client ID can be up to 11 digits.  LMA's local ID (Facility code + client record number) may be submitted and will be cross-referenced for processing in the IPRS.  MR/MI and CTSP may submit their unique ID if cross-referenced. | Required and Edited |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| | | | The patient Medicaid or IPRS client ID is mapped into the MMIS+ and IPRS. | |
| Example: NM1*IL*1*SMITH*JANE****MI*912478911A~ | | | | |
| **Subscriber Address** | | **Occurs 1 time per Loop 2010BA occurrence** | | **Required** |
| N301 - p121 | Address Information | 1/55 | Subscriber Address | HIPAA Requirement |
| Example: N3*456 INNEED STREET~ | | | | |
| **Subscriber City/State/Zip Code** | | **Occurs 1 time per Loop 2010BA occurrence** | | **Required** |
| N401 - p122 | City Name | 2/30 | Subscriber City Name | HIPAA Requirement |
| N402 - p123 | State or Province Code | 2/2 | Subscriber State Code | HIPAA Requirement |
| N403 - p123 | Postal Code | 3/15 | Subscriber Postal Code | HIPAA Requirement |
| Example: N4*WARSAW*NC*27412~ | | | | |
| **Demographic Information** | | **Occurs 1 time per Loop 2010BA occurrence** | | **Required** |
| DMG01 - p124 | Date Time Period Format Qualifier | 2/3 | D8 – Date expressed in format CCYYMMDD. | HIPAA Requirement |
| DMG02 - p125 | Date Time Period | 1/35 | Subscriber DOB. | Required and Edited |
| DMG03 - p125 | Gender Code | 1/1 | F – Female<br>M – Male<br>U – Unknown | HIPAA Requirement |
| Example: DMG*D8*19770615*F~ | | | | |
| **LOOP 2010BB - PAYER NAME** | | **Occurs 1 time per Loop 2000B occurrence** | | |
| **Payer Name** | | **Occurs 1 time per Loop 2010BB occurrence** | | **Required** |
| NM101 - p131 | Entity Identifier Code | 2/3 | PR – Payer | HIPAA Requirement |
| NM102 - p131 | Entity Type Qualifier | 1/1 | 2 – Non-Person Entity | HIPAA Requirement |
| NM103 - p131 | Name Last or Org Name | 1/35 | EDS/NC DHHS<br><br>Covers both DMA and DMH/DD/SA | HIPAA Requirement |
| NM104 | Not Used | | Not used | Optional |
| NM105 | Not Used | | Not used | Optional |
| NM106 | Not Used | | Not used | Optional |
| NM107 | Not Used | | Not used | Optional |
| NM108 - p131 | Identification Code Qualifier | 1/2 | PI – Payer Identification | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| NM109 - p131 | Identification Code | 2/80 | DNC00 - Claims<br>**DNC00** – Medicaid Replacement/Void<br>NCDMH – IPRS Replacement/Void<br><br>When CLM05-3 = '7' or '8', the financial payer must be designated in this field.  When CLM05-3 = '1', this field should contain 'DNC00'. | HIPAA Requirement |
| Example: NM1*PR*2*EDS/NC DHHS*****PI*DNC00~ | | | | |
| **LOOP 2300 – CLAIM INFORMATION** | | **Occurs up to 100 times per Loop 2000B occurrence** | | |
| **Claim Information** | | **Occurs 1 time per Loop 2300 occurrence** | | **Required** |
| CLM01 - p171 | Claim Submitter's Identifier | 1/38 | Provider's internal account number for patient.<br><br>A separate Medical Record Number field has been added – See REF segment below. | Required and Edited |
| CLM02 - p172 | Monetary Amount | 1/18 | Total Claim Charge Amount | Required and Edited |
| CLM03 | Not Used | | Not used | Optional |
| CLM04 | Not Used | | Not used | Optional |
| CLM05 - p171 | Health Care Service Location Information | | Place of Service | |
| CLM05-1 p173 | Facility Type/Place of Service Code Value | 1/2 | 12 – Home<br>22 – Outpatient Hospital<br>99 – Other Unlisted Facility<br><br>See implementation guide p173 for list of additional allowable code values. | Required and Edited |
| CLM05-2 | Not Used | | Not Used | Optional |
| CLM05-3 p173 | Claim Frequency Code | 1/1 | 1 – Original - Admit thru Discharge Claim<br>7 – Replacement  - Adjustment Claim<br>8 – Void – Recoupment Claim | Required and Edited |
| CLM06 - p174 | Yes/No Condition or Response Code | 1/1 | Y – Yes – Provider signature on file code | Required |
| CLM07 - p174 | Provider Accept Assignment Code | 1/1 | A – Assigned | Required |
| CLM08 - | Yes/No Condition or Response Code | 1/1 | Y – Yes – Authorization of benefits to be assigned to | Required |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| p175 | | | the provider. | |
| CLM09 - p175 | Release of Information Code | 1/1 | A-Appropriate Release on Information on File<br><br>I-Informed Consent to Release Medical Information Regulated by Federal Statutes<br><br>M-Provider has limited or restricted ability to release data<br><br>N-Not allowed to release data<br><br>O-On file at Payor<br><br>Y-Provider has signed statement permitting release of data<br><br>**NOTE – CMS recommendation limits field to 'Y' or 'N', however, all values are compliant | Required |
| CLM10 - p177 | Patient Signature Source Code | 1/1 | S – Signed signature authorization form for HCFA-1500 Claim Form block 12 on file. | Required |
| CLM11 - p177 | Related Causes Information | | | Situational - Required when the condition being reported is accident or employment related. |
| CLM11-1 | Related-Causes Code | 2/3 | See implementation guide p176 for requirement conditions and allowable code values.<br><br>AP (Another Party Responsible) – Not mapped in MMIS+<br>AA (Auto Accident)<br>EM (Employment) – defined as On-the-Job Injury<br>OA (Other Accident) - defined as Accidental Injury | HIPAA Requirement |
| CLM11-2 | Not Used | | Not used | Optional |
| CLM11-3 p177 | Not Used | | Not used | Optional |
| CLM11-4 p177 | State or Province Code | 2/2 | Enter state code in which accident occurred. | Situational - Required if CLM11- |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| | | | | 1, -2, or –3 = AA to identify the state in which accident occurred. |
| Example: CLM*777666555*200.50***99::1*Y*A*Y*M*S*AA:::NC~ | | | | |
| **Date – Initial Treatment** | | **Occurs 1 time per Loop 2300 occurrence** | | **Situational - Required for Medicaid Specialized Therapies Services** |
| DTP01 - p183 | Date/Time Qualifier | 3/3 | 454 – Initial Treatment | HIPAA Requirement |
| DTP02 - p183 | Date Time Period Format Qualifier | 2/3 | D8 – Date expressed in format CCYYMMDD | HIPAA Requirement |
| DTP03 - p183 | Date Time Period | 1/35 | Initial Treatment Date | HIPAA Requirement |
| Example: DTP*454*D8*20001001~ | | | | |
| **Date - Accident** | | **Occurs 1 time per Loop 2300 occurrence** | | **Situational - Required if CLM11-1, CLM11-2, or CLM11-3 = AA, AB, AP, or OA.** |
| DTP01 - p194 | Date/Time Qualifier | 3/3 | 439 – Accident | HIPAA Requirement |
| DTP02 - p194 | Date Time Period Format Qualifier | 2/3 | D8 – Date expressed in format CCYYMMDD | HIPAA Requirement |
| DTP03 - p195 | Date Time Period | 1/35 | Date | HIPAA Requirement |
| Example: DTP*439*D8*20001001~ | | | | |
| **Claim Supplemental Information** | | **Occurs 1 time per Loop 2300 occurrence** | | **Situational – Required if Medicare override needed for claim to process** |
| PWK01 – | Report Type Code | 2/2 | OZ-Support Data for Claim | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| p216 | | | | |
| PWK02 – p217 | Report Transmission Code | 1/2 | AA – Available on Request at Provider Site (This combination of values is equivalent to an F2 Stamp) | HIPAA Requirement |
| Example: PWK*OZ*AA~ | | | | |
| **Claim Reference Information** | | **Occurs 1 time per Loop 2300 occurrence** | | **Situational - Required when CLM05-3 = 7 – Replacement or 8 - Void** |
| REF01 – p231 | Reference Identification Qualifier | 2/3 | F8 – Original Reference Number | HIPAA Requirement |
| REF02 – p231 | Claim Original Reference Number | 1/30 | Original ICN for Claim being adjusted or voided | HIPAA Requirement |
| Example: REF*F8*252003035000111~ | | | | |
| **Medical Record Information** | | **Occurs 1 time per Loop 2300 occurrence** | | **Required by IPRS** |
| REF01 – p242 | Reference Identification Qualifier | 2/3 | EA – Medical Record Identification Number | HIPAA Requirement |
| REF02 – p242 | Medical Record Number | 1/30 | Client Medical Record Number | HIPAA Requirement |
| Example: REF*EA*063528~ | | | | |
| **Health Care Diagnosis Code** | | **Occurs 1 time per Loop 2300 occurrence** | | **Required by MMIS+** |
| HI01 - p266 | Health Care Code Information | | | Required and Edited |
| HI01-1 p266 | Code List Qualifier Code | 1/3 | BK – Principal Diagnosis ICD-9 Codes (primary) Reason for treatment is the primary diagnosis in IPRS. | |
| HI01-2 p266 | Industry Code | 1/30 | Diagnosis Code – Do not enter decimal point | |
| HI02 - p267 | Health Care Code Information | | | Optional |
| HI02-1 p267 | Code List Qualifier Code | 1/3 | BF - Diagnosis ICD-9 Codes (secondary) | |
| HI02-2 p267 | Industry Code | 1/30 | Diagnosis Code | |
| HI03 - p268 | Health Care Code Information | | | Optional |
| HI03-1 p268 | Code List Qualifier Code | 1/3 | BF - Diagnosis ICD-9 Codes (third) | |
| HI03-2 p268 | Industry Code | 1/30 | Diagnosis Code | |
| HI04 - p268 | Health Care Code Information | | | Optional |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| HI04-1  p268 | Code List Qualifier Code | 1/3 | BF - Diagnosis ICD-9 Codes (fourth) | |
| HI04-2  p268 | Industry Code | 1/30 | Diagnosis Code | |
| HI05 - p269 | Health Care Code Information | | **The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes** | Optional |
| HI05-1  p269 | Code List Qualifier Code | 1/3 | BF - Diagnosis ICD-9 Codes (fifth) | |
| HI05-2  p269 | Industry Code | 1/30 | Diagnosis Code | |
| HI06 - p269 | Health Care Code Information | | **The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes** | Optional |
| HI06-1  p269 | Code List Qualifier Code | 1/3 | BF - Diagnosis ICD-9 Codes (sixth) | |
| HI06-2  p269 | Industry Code | 1/30 | Diagnosis Code | |
| HI07 - p270 | Health Care Code Information | | **The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes** | Optional |
| HI07-1  p270 | Code List Qualifier Code | 1/3 | BF - Diagnosis ICD-9 Codes (seventh) | |
| HI07-2  p270 | Industry Code | 1/30 | Diagnosis Code | |
| HI08 - p270 | Health Care Code Information | | **The MMIS+ Initial HIPAA Implementation will continue to use only the first 4 diagnosis codes** | Optional |
| HI08-1  p270 | Code List Qualifier Code | 1/3 | BF - Diagnosis ICD-9 Codes (eighth) | |
| HI08-2  p270 | Industry Code | 1/30 | Diagnosis Code | |
| Example: HI*BK:7834*BF:7835*BF:7836*BF:7837*BF:7838*BF:7839*BF:7840*BF:7841~ | | | | |
| **LOOP 2310A - REFERRING PROVIDER NAME** | | **Occurs 1 time per Loop 2300 occurrence** | | **NOTE:  Claims processing will always occur against the Provider data submitted at the header level.** |
| **Referring Provider Name** | | **Occurs 1 time per Loop 2310A occurrence** | | **Required by IPRS** |
| NM101 - p284 | Entity Identifier Code | 2/3 | DN – Referring Provider<br><br>The referring provider is used to determine the responsible LMA, whose budget will be debited to pay for the claim. | HIPAA Requirement |
| NM102 - p284 | Entity Type Qualifier | 1/1 | 2 - Non-Person Entity | HIPAA Requirement |
| NM103 - | Name Last or Organization Name | 1/35 | Organization Name | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| p284 | | | | |
| Example: NM1*DN*2*DUPLIN SAMPSON BILLING~ | | | | |
| **Referring Provider Specialty Information** | | **Occurs 1 time per Loop 2310A occurrence** | | **Optional** |
| PRV01 - p285 | Provider Code | 1/3 | RF - Referring | HIPAA Requirement |
| PRV02 - p285 | Reference Identification Qualifier | 2/3 | ZZ – Mutually Defined Health Care Provider Taxonomy Code | HIPAA Requirement |
| PRV03 - p285 | Reference Identification | 1/30 | 261QM1300X – Ambulatory Health Care Facilities Clinic/Center - Multi-Specialty Provider Taxonomy Code<br><br>**NOTE – Taxonomy codes are updated on a periodic basis.  If submitted, this value will need to be maintained to remain compliant. | HIPAA Requirement |
| Example: PRV*RF*ZZ*261QM1300X~ | | | | |
| **Referring Provider Secondary Information** | | **Occurs up to 5 times per Loop 2310A occurrence** | | **Required by IPRS** |
| REF01 - p288 | Reference Identification Qualifier | 2/3 | 0B – State License Number | HIPAA Requirement |
| REF02 - p288 | Reference Identification | 1/30 | IPRS Provider Number<br><br>Enter the responsible LMA's non-alpha suffix base provider number. | Required and Edited |
| Example: REF*0B*3404045~ | | | | |
| **LOOP 2310B - RENDERING PROVIDER NAME** | | **Occurs 1 time per Loop 2300 occurrence** | | **NOTE:  Claims processing will always occur against the Provider data submitted at the header level.** |
| **Rendering Provider Name** | | **Occurs 1 time per Loop 2310B occurrence** | | **Situational – Required when Rendering Provider is Different from Billing Provider** |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| NM101 - p291 | Entity Identifier Code | 2/3 | 82 – Rendering Provider | HIPAA Requirement |
| NM102 - p291 | Entity Type Qualifier | 1/1 | 1 – Person<br>2 - Non-Person Entity | HIPAA Requirement |
| NM103 - p291 | Name Last or Organization Name | 1/35 | Last Name<br><br>**NOTE – If this is a hard-coded value, recommend coding 'Area Program/Contract Provider'. | HIPAA Requirement |
| NM104 - p291 | Name First | 1/25 | Required if NM102=1 (person) | HIPAA Requirement |
| NM105 - p292 | Not Used | | Not Used | Optional |
| NM106 | Not Used | | Not Used | Optional |
| NM107 - p292 | Not Used | | Not Used | Optional |
| NM108 - p292 | Identification Code Qualifier | 1/2 | Identification Code Qualifier<br><br>Code = 24 if NM101=82 and NM102=2<br>Employer's Identification Number<br><br>Code = 34 if NM101=82 and NM102=1<br>Social Security Number | HIPAA Requirement |
| NM109 - p292 | Identification Code | 2/80 | Tax ID or Social Security Number of Rendering Provider. | HIPAA Requirement |
| Example: NM1*82*1*WELBY*MARCUS****34*333666999~ | | | | |
| **Rendering Provider Specialty Information** | | **Occurs 1 time per Loop 2310B occurrence** | | <mark>**Optional – This segment should not be submitted if the PRV segment is submitted in Loop 2000A**</mark> |
| PRV01 - p293 | Provider Code | 1/3 | PE – Performing | HIPAA Requirement |
| PRV02 - p294 | Reference Identification Qualifier | 2/3 | ZZ – Mutually Defined | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| PRV03 - p294 | Reference Identification | 1/30 | Provider Taxonomy Code -10 digit taxonomy code for the attending provider.<br><br>Taxonomy must comply with HIPAA | HIPAA Requirement |
| Example: PRV*PE*ZZ*103TF000N~ | | | | |
| **Rendering Provider Secondary Information** | | **Occurs up to 5 times per Loop 2310B occurrence** | | **Situational – Required when Rendering Provider is Different from Billing Provider** |
| REF01 - p296 | Reference Identification Qualifier | 2/3 | 0B – State License Number | HIPAA Requirement |
| REF02 - p296 | Reference Identification | 1/30 | IPRS Attending Provider Number<br><br>This can be any enrolled IPRS Billing or Attending Provider number | Required and Edited |
| Example: REF*0B*DS00045~ | | | | |
| **LOOP 2310D SERVICE FACILITY LOCATION** | | **Occurs 1 time per Loop 2300 occurrence** | | |
| **Individual or Organizational Name** | | **Occurs 1 time per Loop 2310D occurrence** | | |
| NM101 - p305 | Entity Identifier Code | 2/3 | 77 – Service Location | HIPAA Requirement |
| NM102 – p305 | Entity Type Qualifier | 1/1 | 2 – Non-Person Entity | HIPAA Requirement |
| NM103 – p305 | Organization Name | 1/35 | Facility Name | Required |
| NM104 | First Name | | | Not Used |
| NM105 | Middle Name | | | Not Used |
| NM106 | Name Prefix | | | Not Used |
| NM107 | Name Suffix | | | Not Used |
| NM108 – p306 | Identification Code Qualifier | 1/2 | 24 – Employer Identification Number<br>34 – Social Security Number | Required |
| NM109 – p306 | Identification Code | 2/80 | Tax ID or Social Security Number of Rendering Provider Agency | Required |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| Example: NM1*77*2*GROUP HOME NAME*****24*56-1234567~ ||||
| **Service Facility Location Address** || **Occurs 1 time per Loop 2310D occurrence** || |
| N301 – p308 | Address Information | 1/55 | Service facility address | HIPAA Requirement |
| Example: N3*456 MAIN STREET~ ||||
| **Service Facility Location City/State/Zip Code** || **Occurs 1 time per Loop 2310D occurrence** || **Required** |
| N401 – p309 | City Name | 2/30 | Service facility location city name. | HIPAA Requirement |
| N402 – p310 | State or Province Code | 2/2 | Service facility location state code. | HIPAA Requirement |
| N403 – p310 | Postal Code | 3/15 | Service facility location zip code. | HIPAA Requirement |
| Example: N4*DUPLIN/SAMPSON*NC*23110~ ||||
| **Service Facility Location Secondary Identification** || **Occurs 1 time per Loop 2310D occurrence** || **Required by IPRS** |
| REF01 – p311 | Reference Identification Qualifier | 2/3 | LU – Location Number | HIPAA Requirement |
| REF02 – p312 | Reference Identification | 1/30 | Enter the agency number as it is enrolled in IPRS. | Required and Edited |
| Example: REF*LU*DS00001P~ ||||
| **LOOP 2320 OTHER SUBSCRIBER INFORMATION** || **Occurs up to 10 times per Loop 2300 occurrence** || |
| **Other Subscriber Information** || **Occurs 1 time per Loop 2320 occurrence** || **Situational – Required when reporting TPL information** |
| SBR01 - p320 | Payer Responsibility Sequence Number Code | 1/1 | P – Primary<br><br>S-Secondary<br><br>T-Tertiary | HIPAA Requirement |
| SBR02 - p320 | Individual Relationship Code | 2/2 | 18 – Self | HIPAA Requirement |
| SBR03 – p321 | Reference Identification | 1/30 | Insured Group or Policy number | Required and Edited |
| SBR04 | Not Used | | Not used | Optional |
| SBR05 - p322 | Insurance Type Code | 1/3 | See implementation guide p322 for list of allowable code values.<br><br>Use code OT (other) if list does not contain appropriate code. | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| SBR06 | Not Used | | Not Used | Optional |
| SBR07 | Not Used | | Not Used | Optional |
| SBR08 | Not Used | | Not Used | Optional |
| SBR09 – p322 | Claim Filing Indicator Code | 1/2 | See implementation guide p322-323 for list of allowable code values. | Required and Edited |
| Example: SBR*P*18*958625**OT****MC~ | | | | |
| **Coordination of Benefits Payer Paid Amount** | | **Occurs 1 time per Loop 2320 occurrence** | | **Required when loop 2320 is reported** |
| AMT01 - p332 | Amount Qualifier Code | 1/3 | D – Payor Amount Paid | HIPAA Requirement |
| AMT02 - p332 | Monetary Amount | 1/18 | Claim Amount Paid<br><br>This is a crosswalk from CLP04 in 835 when doing COB | Edited if reported |
| Example: AMT*D*25.35~ | | | | |
| **Subscriber Demographic Information** | | **Occurs 1 time per Loop 2320 occurrence** | | **Situational – Required when 2330A NM102 = 1** |
| DMG01 - p343 | Date Time Period Format Qualifier | 2/3 | D8 – Date expressed in format CCYYMMDD | HIPAA Requirement |
| DMG02 - p344 | Date Time Period | 1/35 | Subscriber Date of Birth | HIPAA Requirement |
| DMG03 - p344 | Gender Code | 1/1 | F – Female<br>M – Male<br>U – Unknown | HIPAA Requirement |
| Example: DMG*D8*19770615*F~ | | | | |
| **Other Insurance Coverage Information** | | **Occurs 1 time per Loop 2320 occurrence** | | **Required when Loop 2320 is reported** |
| OI01 | Not Used | | Not Used | Optional |
| OI02 | Not Used | | Not Used | Optional |
| OI03 - p346 | Yes/No Condition or Response Code | 2/2 | Y – Yes - Authorize assignment of benefits to be paid directly to the provider<br>N - No | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| OI04 - p346 | Patient Signature Source Code | 1/1 | S – Signed signature authorization form for HCFA-1500 Claim Form block 12 on file. Required except in cases where "N" is used in OI06<br><br>See implementation guide p345 for list of additional code values. | HIPAA Requirement |
| OI05 | Not Used | | Not Used | Optional |
| OI06 - p346 | Release of Information Code | 1/1 | M – The Provider has Limited or Restricted Ability to Release Data Related to a Claim<br><br>See implementation guide p345-346 for list of additional code values. | HIPAA Requirement |
| Example: OI***Y*S**M~ | | | | |
| **LOOP ID - 2330A OTHER SUBSCRIBER NAME** | | **Occurs 1 time per Loop 2300 occurrence** | | |
| **Other Subscriber Name** | | **Occurs 1 time per Loop 2330A occurrence** | | **Required when Loop 2320 is reported** |
| NM101 - p351 | Entity Identifier Code | 2/3 | IL – Insured or Subscriber | HIPAA Requirement |
| NM102 - p351 | Entity Type Qualifier | 1/1 | 1 – Person | HIPAA Requirement |
| NM103 - p351 | Name Last or Organization Name | 1/35 | Last name of subscriber (patient). | Required and Edited |
| NM104 - p351 | Name First | 1/25 | Enter first name of subscriber (patient). Required if NM102 = 1 | Required and Edited |
| NM105 - p351 | Name Middle | 1/25 | Middle Initial | Optional |
| NM106 | Not Used | | Not Used | Optional |
| NM107 - p352 | Not Used | | Not Used | Optional |
| NM108 - p353 | Identification Code Qualifier | 1/2 | MI – Member Identification number. | HIPAA Requirement |
| NM109 - p353 | Identification Code | 2/80 | Other Subscriber Identifier | Required and Edited |
| Example: NM1*IL*1*SMITH*JANE****MI*912478911B~ | | | | |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|

| LOOP ID - 2330B OTHER PAYER NAME | | Occurs 1 time per Loop 2300 occurrence | | |
|---|---|---|---|---|
| Other Payer Name | | Occurs 1 time per Loop 2330B occurrence | | Required when Loop 2320 is reported |
| NM101 - p360 | Entity Identifier Code | 2/3 | PR – Payer | HIPAA Requirement |
| NM102 - p360 | Entity Type Qualifier | 1/1 | 2 – Non-Person Entity | HIPAA Requirement |
| NM103 - p360 | Name Last or Organization Name | 1/35 | Enter other payer name. | HIPAA Requirement |
| NM104 | Not Used | | Not Used | Optional |
| NM105 | Not Used | | Not Used | Optional |
| NM106 | Not Used | | Not Used | Optional |
| NM107 | Not Used | | Not Used | Optional |
| NM108 - p360 | Identification Code Qualifier | 1/2 | PI – Payor Identification | HIPAA Requirement |
| NM109 - p361 | Identification Code | 2/80 | Identification Code | HIPAA Requirement |
| Example: NM1*PR*2*MEDICARE*****PI*0000000~ | | | | |
| Date Paid | | Occurs 1 time per Loop 2330B occurrence | | Situational - Required when Loop 2430 is not reported |
| DTP01 – p367 | Date Time Qualifier | 3/3 | 573 - Date Claim Paid | HIPAA Requirement |
| DTP02 – p367 | Date Time Period Format Qualifier | 2/3 | D8 – Date expressed in format CCYYMMDD | HIPAA Requirement |
| DTP03 – p368 | Adjudication or Payment Date | 1/35 | Paid Date | HIPAA Requirement |
| Example: DTP*573*D8*20030205~ | | | | |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| **Other Payer Secondary Identifier** | | | **Occurs up to 2 times per Loop 2330B occurrence** | **Situational - Required when Loop 2320 is reported and Secondary Payer Identification is needed** |
| REF01 – p369 | Reference Identification Qualifier | 2/3 | 2U-Payer ID Number<br><br>FY-Claim Office Number<br><br>NF-NAIC Code<br><br>TJ-Federal Taxpayer's ID Number<br><br><br>(F8-Original Ref # - Not Valid for Providers) | HIPAA Requirement |
| REF02 – p370 | Reference Identification | 1/30 | Other Payer Claim Reference number | Required and Edited |
| Example: REF*TJ*561020225~ | | | | |
| **LOOP 2400 - SERVICE LINE** | | **Occurs up to 50 times per Loop 2300 occurrence** | | |
| **Service Line** | | **Occurs 1 time per Loop 2400 occurrence** | | **Required** |
| LX01 - p398 | Assigned Number | 1/6 | Enter service line number starting with 01, incrementing by 1<br><br>IPRS recommends 1 detail per claim to avoid total claim denial as a result of 1 denied detail. | HIPAA Requirement |
| Example: LX*01~ | | | | |
| **Professional Service** | | **Occurs 1 time per Loop 2400 occurrence** | | **Required** |
| SV101 - p400 | Composite Medical Procedure Identifier | | | |
| SV101-1 p401 | Product/Service ID Qualifier | 2/2 | HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes." | HIPAA Requirement |
| SV101-2 p402 | Product/Service ID | 1/48 | Procedure Code | Required and Edited |
| SV101-3 - p402 | Procedure Modifier | 2/2 | Procedure Code Modifier-1 | Optional |
| SV101-4 – | Procedure Modifier | 2/2 | Procedure Code Modifier-2 | Optional |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| p402 | | | | |
| SV101-5 – p403 | Procedure Modifier | 2/2 | Procedure Code Modifier-3 | Optional |
| SV101-6 – p403 | Procedure Modifier | 2/2 | Procedure Code Modifier-4 | Optional |
| SV101-7 | Not Used | | Not Used | Optional |
| SV102 - p403 | Monetary Amount | 1/18 | Submitted charge amount including the decimal. | Required and Edited |
| SV103 - p404 | Unit or Basis for Measurement Code | 2/2 | UN – Unit | HIPAA Requirement |
| SV104 - p404 | Quantity | 1/15 | HCPCS/CPT codes are submitted as 1 unit per day.<br><br>IPRS-only procedures are reported in 15 minute intervals unless specified as daily in the IPRS Audits Manual:<br>   1 unit  = 15 minutes<br>   2 units = 30 minutes etc.<br>Units may be reported using a decimal value if needed. | Required and Edited |
| SV105 - p405 | Place of Service | 1/2 | Detail Place of Service | Situational – Required only when different from value reported in CLM05-1 |
| SV106 - p405 | Service Type Code | 1/2 | No Longer stored in MMIS+ | Optional |
| SV107 - p405 | Composite Diagnosis Code Pointer | | Used to identify one or more diagnosis code pointers. | Optional |
| SV107-1 p405 | Diagnosis Code Pointer | 1/2 | 1 - Use this pointer for the first diagnosis code pointer (primary diagnosis for this service line). | HIPAA Requirement |
| SV107-2 | Not Used | | Not Used | Optional |
| SV107-3 | Not Used | | Not Used | Optional |
| SV107-4 | Not Used | | Not Used | Optional |
| SV108 | Not Used | | Not Used | Optional |
| SV109 - p407 | Yes/No Condition or Response Code | 1/1 | Y –Emergency Indicator | Situational – Required only when reporting an Emergency |
| Example: SV1*HC:YP498*20.50*UN*2*12**1**Y~ | | | | |
| **Service Date** | | | **Occurs 1 time per Loop 2400 occurrence** | **Required** |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| DTP01 - p435 | Date/Time Qualifier | 3/3 | 472 – Service | HIPAA Requirement |
| DTP02 - p436 | Date/Time Period Format Qualifier | 2/3 | RD8 | HIPAA Requirement |
| DTP03 - p436 | Date Time Period | 1/35 | Enter date range in CCYYMMDD - CCYYMMDD format. The date range represents the from/to dates in the MMIS+ and IPRS.  Entering the same date for the from/to date is also a valid entry. | Required and Edited |
| Example: DTP*472*RD8*20001001-20001001~ | | | | |
| **Line Item Control Number** | | **Occurs 1 time per Loop 2400 occurrence** | | **Required by IPRS** |
| REF01 - p472 | Reference Identification Qualifier | 2/3 | 6R – Provider Control Number | HIPAA Requirement |
| REF02 - p473 | Reference Identification | 1/30 | Line Item Control Number | Required and Edited |
| Example: REF*6R*123456789~ | | | | |
| **LOOP 2420A - RENDERING PROVIDER NUMBER** | | **Occurs 1 time per Loop 2400 occurrence** | | **NOTE: Provider information reported at the detail level is informational only in MMIS+.  Claims process based on header level data only.** |
| **Rendering Provider Name** | | **Occurs 1 time per Loop 2420A occurrence** | | **Situational – Report if different from Header Rendering Provider Data** |
| NM101 - p502 | Entity Identifier Code | 2/3 | 82 – Rendering Provider | HIPAA Requirement |
| NM102 - p502 | Entity Type Qualifier | 1/1 | 1 – Person<br>2 – Non-Person Entity | HIPAA Requirement |
| NM103 - p502 | Name Last or Organization Name | 1/35 | Rendering provider last name.<br><br>**NOTE – If this is a hard-coded value, recommend | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| | | | coding 'Area Program/Contract Provider'. | |
| NM104 - p502 | Name First | 1/25 | Required if NM102=1 (person) | HIPAA Requirement |
| NM105 – p502 | Not Used | | Not Used | Optional |
| NM106 | Not Used | | Not Used | Optional |
| NM107 – p502 | Not used | | Not Used | Optional |
| NM108 – p502 | Identification Code Qualifier | 1/2 | Identification Code Qualifier  Code = 24 if NM101=82 and NM102=2 Employer's Identification Number  Code = 34 if NM101=82 and NM102=1 Social Security Number | HIPAA Requirement |
| NM109 – p502 | Identification Code | 2/80 | Tax ID or Social Security Number of Rendering Provider. | HIPAA Requirement |
| Example: NM1*82*1*WELBY*MARCUS****34*333666999~ | | | | |
| **Rendering Provider Specialty Information** | | **Occurs 1 time per Loop 2420A occurrence** | | **Optional** |
| PRV01 - p504 | Provider Code | 1/3 | PE – Rendering | HIPAA Requirement |
| PRV02 - p504 | Reference Identification Qualifier | 2/3 | ZZ – Mutually Defined | HIPAA Requirement |
| PRV03 - p504 | Provider Taxonomy Code | 1/30 | Provider Taxonomy Code -10 digit taxonomy code for the attending provider.  Must Comply with HIPAA | HIPAA Requirement |
| Example: PRV*PE*ZZ*103TF000N~ | | | | |
| **Rendering Provider Secondary Identification** | | **Occurs up to 5 times per Loop 2420A occurrence** | | **Situational – Required when Loop 2420A is reported** |
| REF01 - p507 | Reference Identification Qualifier | 2/3 | 0B – State License Number | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| REF02 - p507 | Rendering Provider Secondary Identifier | 1/30 | IPRS Attending Provider Number<br><br>This can be any enrolled IPRS Billing or Attending Provider number | Required and Edited |
| Example: REF*0B*DS00025~ | | | | |
| **LOOP 2420F - REFERRING PROVIDER NUMBER** | | **Occurs 1 time per Loop 2400 occurrence** | | **NOTE: Provider information reported at the detail level is informational only in MMIS+. Claims process based on header level data only.** |
| **Referring Provider Name** | | **Occurs 1 time per Loop 2420F occurrence** | | **Situational – Report if different from Header Referring Provider Data** |
| NM101 - p542 | Entity Identifier Code | 2/3 | DN – Referring Provider<br><br>The referring provider is used to determine the responsible LMA, whose budget will be debited to pay for the claim. | HIPAA Requirement |
| NM102 - p542 | Entity Type Qualifier | 1/1 | 1 – Person | HIPAA Requirement |
| NM103 - p542 | Name Last or Organization Name | 1/35 | Referring provider last name. | HIPAA Requirement |
| NM104 - p542 | Name First | 1/25 | Referring provider first name. | HIPAA Requirement |
| Example: NM1*DN*1*DUPLIN SAMPSON*BILLING*~ | | | | |
| **Referring Provider Specialty Information** | | **Occurs 1 time per Loop 2420F occurrence** | | **Optional** |
| PRV01 - p544 | Provider Code | 1/3 | RF – Referring | HIPAA Requirement |
| PRV02 - p545 | Reference Identification Qualifier | 2/3 | ZZ – Mutually Defined Health Care Provider Taxonomy Code | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| PRV03 - p545 | Reference Identification | 1/30 | 261QM1300X – Ambulatory Health Care Facilities Clinic/Center - Multi-Specialty Provider Taxonomy Code

**NOTE – Taxonomy codes are updated on a periodic basis.  If submitted, this value will need to be maintained to remain compliant. | HIPAA Requirement |
| Example: PRV*RF*ZZ*261QM1300X~ | | | | |
| **Referring Provider Secondary Identification** | | **Occurs up to 5 times per Loop 2420F occurrence** | | **Required by IPRS when Loop 2420F is reported** |
| REF01 - p547 | Reference Identification Qualifier | 2/3 | 0B – State License Number | HIPAA Requirement |
| REF02 - p548 | Reference Identification | 1/30 | Provider ID

Enter the responsible LMA's non-alpha suffix base provider number. | Required and Edited |
| Example: REF*0B*3404046~ | | | | |
| **LOOP 2430 – LINE ADJUDICATION INFORMATION** | | **Occurs up to 25 times per Loop 2400 occurrence** | | **Situational - Required when reporting TPL in LOOP 2330B for this detail** |
| **Service Line Adjudication** | | **Occurs 1 time per Loop 2430 occurrence** | | **Required** |
| SVD01 – p556 | Other Payer Primary Identifier | 2/80 | Should match the value in NM109 of the 2330B loop for identifying Other Payer. | HIPAA Requirement |
| SVD02 - p556 | Service Line Paid Amount | 1/18 | TPL Detail Amount Paid | HIPAA Requirement |
| SVD03 – p556 | Composite Medical Procedure Identifier | | | |
| SVD03-1 p556 | Product/Service ID Qualifier | 2/2 | HC – Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes. ZZ-Mutually Defined | HIPAA Requirement |
| SVD03-2 p557 | Product/Service ID | 1/48 | Procedure Code | Required and Edited |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| SVD03-3 p557 | Procedure Modifier | 2/2 | Procedure Code Modifier-1 | Optional |
| SVD03-4 p557 | Procedure Modifier | 2/2 | Procedure Code Modifier-2 | Optional |
| SVD03-5 p557 | Procedure Modifier | 2/2 | Procedure Code Modifier-3 | Optional |
| SVD03-6 p557 | Procedure Modifier | 2/2 | Procedure Code Modifier-4 | Optional |
| SVD03-7 p558 | Not Used | | Not Used | Optional |
| SVD04 – p558 | Not Used | | Not Used | Optional |
| SVD05 – p558 | Paid Service Unit Count | 1/15 | HCPCS/CPT codes are submitted as 1 unit per day.  Units may be reported using a decimal value if needed. | Required and Edited |
| SVD06 - p558 | Bundled Line Number | 1/6 | Bundled/Unbundled Line Number | Situational – Required if payer bundled/unbundled this service line. |
| Example: SVD*0000000*20.50*HC:YP498***2~ | | | | |
| **Line Adjustment Reason Information** | | **Occurs up to 99 times per Loop 2430 occurrence** | | **Situational - Required when TPL Amount Paid is different from TPL Amount originally Billed** |
| CAS01 - p561 | Claim Adjustment Group Code | 1/2 | See Implementation guide p561 for allowable code values. | HIPAA Requirement |
| CAS02 - p561 | Claim Adjustment Reason Code - 1 | 1/5 | Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C. | HIPAA Requirement |
| CAS03 - p561 | Adjustment Amount - 1 | 1/18 | Adjusted Amount | HIPAA Requirement |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| CAS04 | Not Used | | Not Used | Optional |
| CAS05 - p562 | Claim Adjustment Reason Code - 2 | 1/5 | Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C. | Optional |
| CAS06 - p562 | Adjustment Amount - 2 | 1/18 | Adjusted Amount | Optional |
| CAS07 | Not Used | | Not Used | Optional |
| CAS08 - p563 | Claim Adjustment Reason Code - 3 | 1/5 | Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C. | Optional |
| CAS09 - p563 | Adjustment Amount - 3 | 1/18 | Adjusted Amount | Optional |
| CAS10 | Not Used | | Not Used | Optional |
| CAS11 - p564 | Claim Adjustment Reason Code - 4 | 1/5 | Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C. | Optional |
| CAS12 - p564 | Adjustment Amount - 4 | 1/18 | Adjusted Amount | Optional |
| CAS13 | Not Used | | Not Used | Optional |
| CAS14 - p565 | Claim Adjustment Reason Code - 5 | 1/5 | Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C. | Optional |
| CAS15 - p565 | Adjustment Amount - 5 | 1/18 | Adjusted Amount | Optional |
| CAS16 | Not Used | | Not Used | Optional |
| CAS17 - p566 | Claim Adjustment Reason Code - 6 | 1/5 | Use the Claim Adjustment Reason Code List – See Implementation Guide Appendix C. | Optional |
| CAS18 - p566 | Adjustment Amount - 6 | 1/18 | Adjusted Amount | Optional |

| HIPAA FIELD - PAGE# | HIPAA FIELD NAME | FIELD LENGTH | DATA CONTENT | COMMENT |
|---|---|---|---|---|
| CAS19 | Not Used | | Not Used | Optional |
| **Example: CAS*OA*1*20.00~** | | | | |
| **Date Paid** | | **Occurs 1 time per Loop 2430 occurrence** | | **Required** |
| DTP01 – p567 | Date Time Qualifier | 3/3 | 573 - Date Claim Paid | HIPAA Requirement |
| DTP02 – p567 | Date Time Period Format Qualifier | 2/3 | D8 – Date expressed in format CCYYMMDD | HIPAA Requirement |
| DTP03 – p567 | Adjudication or Payment Date | 1/35 | Paid Date | HIPAA Requirement |
| Example: DTP*573*D8*20030205~ | | | | |
| **TRANSACTION SET TRAILER** | | **Occurs 1 time** | | **Required** |
| SE01 - p572 | Number of Included Segments | 1/10 | Transaction Segment Count | HIPAA Requirement |
| SE02 - p572 | Transaction Set Control Number | 4/9 | Transaction Set Control Number Numbers in ST02 and SE02 must be identical. | HIPAA Requirement |
| Example: SE*32*918273645~ | | | | |
| **FUNCTIONAL GROUP TRAILER** | | **Occurs 1 time** | | **Required** |
| GE | Interchange Control Header | 3/3 | GE | HIPAA Requirement |
| GE01 | Number of Transaction Sets | 2/2 | Number of Transaction Sets (ST - SE) | HIPAA Requirement |
| GE02 | Group Control Number | 10/10 | Must =- GS06 | HIPAA Requirement |
| Example of Segment    GE*1*0001~ | | | | |
| **INTERCHANGE CONTROL TRAILER** | | **Occurs 1 time** | | **Required** |
| IEA | Interchange Control Header | 3/3 | IEA | HIPAA Requirement |
| IEA01 | Number of Included Functional Groups | 1/5 | Number of function groups (GS - GE) | HIPAA Requirement |
| IEA02 | Interchange Control Number | 9/9 | Must = ISA13 | HIPAA Requirement |
| Example of Segment    IEA*1*000000001~ | | | | |